MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

02412

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Maryland Hotel Apartments
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Maryland Hotel Apt.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Armstrong

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Joseph M. Armstrong
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 12th 1866

8. AGE: Years 80 | Months 7 | Days 24 | If less than one day ... hrs. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Edward B. Johnson
13. Birthplace Penn.

MOTHER 14. Maiden name Betty Hudson
15. Birthplace England

16. Informant Jos M Armstrong
Address Md Hotel Apt. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 11th 1947 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md.

18. Funeral director John M. Taylor, Son
Address Annapolis Md.

19. March 11 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947 at 7.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1947, to March 8 1947
and that I last saw h[er] alive on March 8 1947

Immediate cause of death	DURATION
Acute Oedema of Lungs	24 hrs
Due to Cardio Vascular Failure	Several Days
Due to Arterial Hypertension	Several yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE J Oliver Purse, M. D. or other
Address Annapolis Md Date signed 3/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ra)

02413

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:

County A.A.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Years

Hospital, Institution, or street address where death occurred:
292 West Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 292 West Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Joseph Bailey

3.(b) Social Security Number I80-05-640I

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Pauline C. Bailey

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Oct 2I I886

8. AGE: Years	Months	Days	If less than one day
60	5		hrs. min.

9. Birthplace St. Clair, Pa. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Enginer

FATHER
12. Name William J. Bailey
13. Birthplace Pa.

MOTHER
14. Maiden name Elizabeth McGarity
15. Birthplace Pa.

16. Informant Pauline C. Bailey

Address 292 West Street. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 24 I947 (month) (day) (year)

Cemetery or crematory St Marys

Location Annapolis, Md.

18. Funeral director B.L.Hopping&Son

Address Annapolis, Md.

19. March 24, 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 19 47, at 4p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 19 47, to March 21 19 47

and that I last saw h[illegible] alive on March 21 19 47

	DURATION
Immediate cause of death Cerebral Hemorrhage	Several min.
Due to Hypertension	unkn
Due to	
Other conditions Arteriosclerosis	unkn

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other

Address Annapolis Md Date signed 3.22.47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

02414

Reg. Diat. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Charles Behlke | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Alice Behlke
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) June 12 1873

8. AGE: Years	Months	Days	If less than one day
73	9	11	....hrs. ....min.

9. Birthplace Trenton N. J. (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business
FATHER 12. Name Joseph Behlke
13. Birthplace Germany
MOTHER 14. Maiden name Wilhelmina Witt
15. Birthplace Germany
16. Informant Alice Behlke
Address Mayo a a Co Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 15-1947 (month) (day) (year)
Cemetery or crematory Memorial
Location Mayo Md.
18. Funeral director Robert F. Suite
Address Annapolis Md.
19. March 17 1947 (Date rec'd by registrar) Edward Collenson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12th 1947, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1946 to March 12th 1947
and that I last saw him alive on March 9th 1947

Immediate cause of death	DURATION
Coronary heart disease	10 years
Due to Arteriosclerosis	
Due to R	
Other conditions Bright's disease	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edith Rollins M.D.
M. D. or other
Address 42 State Circle Annapolis Md. Date signed 3-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (922)

CERTIFICATE OF DEATH

Reg. Dist. No. 27 (2415)

1. PLACE OF DEATH:

County A. A.

City or town Elvaton, P. O. Millersville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A.

City or town Elvaton
(If outside city or town limits, write RURAL and give nearest town)

Street No. P. O. Millersville, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JOSEPH BERNAT

3. (b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Rose Novotny Bernat

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 7, 1858

8. AGE: Years	Months	Days	If less than one day
89	-	21	..... hrs. ..... min.

9. Birthplace Chechoslovakia
(Town, county, and state)

10. Usual occupation retired

11. Industry or business

FATHER 12. Name unknown

13. Birthplace " "

MOTHER 14. Maiden name " "

15. Birthplace " "

16. Informant Emil Antos

Address Elvaton, Md.

17. Burial Date thereof 3-31-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Baltimore, Md.

18. Funeral director Chas. E. Schimunek

Address 2601-03 E. Madison st.

19. 3-28 1947 L. A. Bleer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1947, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14 1946, to March 27 1947

and that I last saw him alive on March 27 1947

Immediate cause of death	DURATION
Valvular heart disease	indefin.
decompensated past 6 months	
Due to	
Due to	
Other conditions Arteriosclerosis	" "
Senility	" "

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. A. Bleer, M. D.

Address Pasadena, Md. M. D. or other

Date signed 3-31-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

02416

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 Severn Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Enos A. Brewer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 12th 1874

8. AGE:

Years	Months	Days	If less than one day
73	2	11	hrs. min.

9. Birthplace: A. A. Co. Md.

(Town, county, and state)

10. Usual occupation: Ret. Boat builder

11. Industry or business

FATHER

12. Name: Enos Brewer

13. Birthplace: Maryland

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Chas Enos Brewer

Address: 766 Carroll St. Balto 30 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 26th 1947 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Layton Son

Address: Annapolis Md.

19. March 26 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 19 47 at 11:50 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1 19 47, to March 23 19 47

and that I last saw h 17 alive on March 23 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. D. or other

Address: Eastport, Md Date signed 3/26/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21st)

CERTIFICATE OF DEATH

02417

Reg. Dist. No. 201

1. PLACE OF DEATH:
County Anne Arundel
City or town Neale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Neale, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Roger Taney Brooke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

8.(b) Name of husband or wife
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 1867

8. AGE: Years 79 | Months 5 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Leeland P.O. Geo., Md (Town, county, and state)
10. Usual occupation Gen. Foreman - Penn RR
11. Industry or business Railroad
FATHER 12. Name John B. Brooke
13. Birthplace Rossville, Md
MOTHER 14. Maiden name Helen Hill Brooke
15. Birthplace Upper Marlboro, Md
16. Informant Harry Brooke
Address Neale, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-19-47 (month) (day) (year)
Cemetery or crematory W.J. Carmel
Location Upper Marlboro Md
18. Funeral director Pitsie Brothers
Address Upper Marlboro Md
19. 3/19/47 19.... W.H. Clayton Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Mar 19 47, at 1 55 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.... and that I last saw h..... alive on ..... 19....

Immediate cause of death	DURATION
Coronary Thrombosis	1/2 hr
Due to Arteriosclerotic Cardio-vascular Disease	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of ....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert B Sasser M. D. or other
Address Upper Marlboro, Md Date signed 17 Mar 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 02118

1. PLACE OF DEATH:
County Anne Arundel
City or town Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years.
Hospital, Institution, or street address where death occurred:
Whitney Landing
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town P.O. Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. Whitney Landing
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward Thomas Coleman

3.(b) Social Security Number ~~AO~~ 186-09-6554

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife Mrs Katherine Roberts
6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Sept. 12 1896

8. AGE:

Years	Months	Days	If less than one day
50	6	17	..... hrs. ..... min.

9. Birthplace Towanda - Pennsylvania
(Town, county, and state)
10. Usual occupation Post Exchange Clerk
11. Industry or business
FATHER 12. Name Thomas Coleman
13. Birthplace Pennsylvania
MOTHER 14. Maiden name Mary Maynard
15. Birthplace Pennsylvania
16. Informant Mrs. Katherine Coleman
Address Whitney Landing - P.O Severna Park
17. Removal (Burial, cremation, or removal. Which?) Date thereof March 31/47 (month) (day) (year)
Cemetery or crematory
Location Waverly Md York
18. Funeral director H. L. Hopping & Son
Address Annapolis - Md.
19. March 31, 19 47 (Date rec'd by registrar) L. A. Dean Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 47, at 4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Disease	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide NO Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Fauber Jr. M. D. or other
Assistant Medical Examiner
Address Glen Burnie Md Date signed 3/31/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02419

Reg. Diat. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Defense Highway
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Defense Highway
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James T. Cox Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: May Emma Cox
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9th 1873

8. AGE: Years 73 | Months 9 | Days 24 | If less than one day: hrs. min.

9. Birthplace: Prince Geo Co Md
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: James T. Cox
13. Birthplace: Maryland

MOTHER
14. Maiden name: Josephine Duckett
15. Birthplace: A A Co Md

16. Informant: James T. Cox Jr.
Address: Davidsonville A A Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 8th 1947 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Davidsonville A A Co Md

18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. March 6, 1947 (Date rec'd by registrar)
Registrar: C. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 1947, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to March 5 1947 and that I last saw h[illegible] alive on March 5 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Few days
Due to (Antecedent)	
Due to	
Other conditions: Paralysis agitans	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L Anderson M.D.
M. D. or other
Address: Annapolis Md Date signed 3/6/47

02420

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 280

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 2 mos. 2 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 2 yrs. 2 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Georgiana Dent

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Sydney Dent
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1916

8. AGE: Years	Months	Days	If less than one day
30	?	?	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: —

FATHER
12. Name: Joseph Smith
13. Birthplace: ?

MOTHER
14. Maiden name: Unknown
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address:

17. (Burial, cremation, or removal. Which?) burial Date thereof (month) (day) (year)
Cemetery or crematory: St. John's
Location: Clinton, Md.
18. Funeral director: J. B. Johnson
Address: Lafayette Ave Annapolis
19. 3/8/47 19... E. T. Joyce Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1947, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1945 to March 8 1947 and that I last saw her alive on March 8 1947

	DURATION
Immediate cause of death: Lung Tuberculosis	Known to us since 12/6/46
Due to:	
Due to:	
Other conditions: Schizophrenia, simple type	Known to us since 1/5/45

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. V. Whitehead M. D. or other
Address: Crownsville, Maryland Date signed: 3/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Charles H. Stinson

1-35

Evidence for the change of usual residence of deceased & name of husband is shown on G 110 5/15/47

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

C2421

Reg. Diat. No. 280

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 months and 17 days

Hospital, institution, or street address where death occurred: 15 months and 17 days

How long in hospital or institution? Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No.: ~~Pennsylvania Ave.~~ 208½ North Jonathan St. ~~40W.Bethel Street~~ (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Doleman - Lettie Anne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: ~~Isaac Doleman~~ Ceasar Chatman Doleman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 25, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	21	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: Frank Allen

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Ellen Belle Warfield

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville State Hoapital

17. burial (Burial, cremation, or removal. Which?) Date thereof 3/24-47 (month) (day) (year)

Cemetery or crematory: Hagerstown Md

Location .....

18. Funeral director: Wm H Downey John R Watson

Address: 291 Fredrick Hagerstown md.

19. 3/24 1947 (Date rec'd by registrar) E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1947 19..... at 6-06 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 1945 to March 16 1947

and that I last saw h.. alive on March 16 1947

Immediate cause of death: cerebral arteriosclerosis DURATION

Due to: ..... known to us since admission Nov. 30 45

Due to: .....

Other conditions: Senile Psychosis, simple deterioration

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: ..... Date signed 3/16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1 - 55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35)

CERTIFICATE OF DEATH

02422

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Parole

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:

Fair Fax Road

How long in hospital or institution? ———

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Parole Md near Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fair Fax Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Marjorie Alathia Donnell

3.(b) Social Security Number: ***-**-****

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ...years

7. Birth date of deceased (mo., day, yr.): June ~~15~~ 13, 1946

8. AGE:

Years	Months	Days	If less than one day
	9	11	...hrs. ...min.

9. Birthplace: Fair Fax Road (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: James Donnell

13. Birthplace: West River Md.

MOTHER

14. Maiden name: Lucille Johns

15. Birthplace: Parole Md.

16. Informant: Lucille Donnell

Address: Fair Fax Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/1947 (month) (day) (year)

Cemetery or crematory: Fowles Chapel

Location: East Gate Maryland

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. March 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1947 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1947, to March 26, 1947

and that I last saw h.. alive on March 26, 1947

Immediate cause of death	DURATION
Bronchio-Pneumonia	3 days
Due to: measles	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.: ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: R. E. Richardson M. D. or other

Address: 118 - Clay St. Annapolis, Md. Date signed: 3/28/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Evidence for addition of birth date shown on Film D109-3/19/47-B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C2423

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 44 Lafayette Ave
How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 44 Lafayette Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Maggie Dorsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	colored	widow

6.(b) Name of husband or wife George Dorsey
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 9, 1867

8. AGE: Years 79 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace A. A. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden name Unknown
15. Birthplace

16. Informant Godfrey Lawson
Address 44 Lafayette Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 11 1947 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location Annapolis

18. Funeral director J. B. Johnson
Address Annapolis

19. Mar. 10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 7 1947, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1947, to March 7 1947
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cardiac Failure	2 dys
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE ... M. D. or other
Address 40 Fleet St Apt ... Date signed 3/7/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

12424

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-1

CERTIFICATE OF DEATH

Reg. Dist. No. 280

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Be
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1918 Madison Avenue (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Harriet Dotson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Jimmy Dotson
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
43 ?	?	?	...hrs. ...min.

8. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: ?
11. Industry or business: ?

FATHER
12. Name: Charles ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

18. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Hospital (Burial, cremation, or removal. Which?) Date thereof 4/2-47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Asylum Hospital.
Address: Crownsville Md

19. 4/2 47 E T Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1947 at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1947 to March 18 1947 and that I last saw her alive on March 18 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: Known to us 3 days

Due to: Brain Tumor; Nature, unknown.
Diagnosis established on clinical data. Cushing

Due to:

Other conditions: Psychosis with brain tumor Known to us since 3/1/47
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No autopsy was performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert V. Hazlehurst M. D. or other
Address: Crownsville, Maryland Date signed: 3/18/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 — 55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(2425

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A.A. Co.
City or town: Jessup.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A. Co.
City or town: Jessup
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Camp Meade Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Ellsworth H. Evans.

3.(b) Social Security Number 216-14-8767 A.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M.

6.(b) Name of husband or wife: Elnora L. M.
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): Oct 5. 1878

8. AGE: Years	Months	Days	If less than one day
68	5	25	..... hrs. ..... min.

9. Birthplace: Balto Co.
(Town, county, and state)
10. Usual occupation: Retired Salesman
11. Industry or business
FATHER 12. Name: John H. Evans
13. Birthplace: Md
MOTHER 14. Maiden name: Mary E. Morrison
15. Birthplace: Md.
16. Informant: Elnora Evans
Address: Jessup Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/3/47 (month) (day) (year)
Cemetery or crematory: Meadow Ridge Cem
Location: Dorsey Rd. & Wash. Blvd.
18. Funeral director: Wm Cook Jose
Address: 1317 St Paul St

19. Date rec'd by registrar: Apr 8 1947 — C.W. Hedrick — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 30-47 19.. at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1. 47 to Mar. 30th 19.47
and that I last saw him alive on March 30th 19.47

	DURATION
Immediate cause of death: Cor. Myocardial Insuff.	1 yr.
Due to:	
Due to:	
Other conditions: La Grippe	1 wk.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank Shipley, M.D.
Address: Savage, Md. M. D. or other
Date signed: 3/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

02426

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 711 Severn Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Madeline L. Ford

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Frank T. Ford
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jany 6th 1873

8. AGE:

Years	Months	Days	If less than one day
74	1	26	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: Otto Bon Roden
13. Birthplace: Germany
MOTHER 14. Maiden name: Ida Rafich
15. Birthplace: Germany
16. Informant: Mrs Robert J. Basham
Address: 711 Severn Ave Eastport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 7th 1947 (month) (day) (year)
Cemetery or crematory:
Location: Towanda Penn.
18. Funeral director: John W. Taylor Son
Address: Annapolis Md.
19. March 4 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1947, at 11:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 11, 1947 to March 3, 1947
and that I last saw her alive on March 3, 1947

Immediate cause of death	DURATION
Acute Dilatation of the Heart	2 days.
Due to Primary Carcinoma of intestines. C.U.S.P.	
Due to	
Other conditions: Generalized Circumvalates (Liver, Stomach, Scalp, etc.)	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other
Address: Annapolis Md. Date signed: 3/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

02427 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 miles ap.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Benfield Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME: William R. Frazer — **3.(b) Social Security Number:** .....

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Virgie
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan 9 - 1878
8. AGE: Years: 69 Months: 2 Days: 7 If less than one day: ..... hrs. ..... min.
9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired
FATHER 12. Name: Richard Frazer
13. Birthplace: So. Carolina
MOTHER 14. Maiden name: Catherine Burke
15. Birthplace: Balto Md.
16. Informant: Mrs Catherine Link
Address: 6040 Harford Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/29/47 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cem
Location: 2930 Frederick Rd
18. Funeral director: John F Cowan & Son
Address: 904-03 Hollins St
19. 3/27 19 47 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26-47 19 ..... at 12:45 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10-47 19 ..... to March 26-47 19 ..... and that I last saw h... alive on March 25-47 19 .....

Immediate cause of death	DURATION
(a) Coat Conductor Failure	2 days
Due to: (b) Arteriosclerotic Hypertension	
Due to: (c)	
Other conditions: Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?
23. SIGNATURE: W M Lipsky M. D. or other
Address: Odenton Md Date signed: March 26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02428

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Nutwell
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Nutwell
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Joseph L. Gibson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie Ford Gibson
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): June 12, 1889

8. AGE: Years	Months	Days	If less than one day
57	8	21	...hrs. ...min.

9. Birthplace: Baltimore City (Town, County, and State)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Samuel R. Gibson
13. Birthplace: Calvert Co. Md

MOTHER
14. Maiden name: Mary r. Claus
15. Birthplace: Baltimore Ciyt, Md

16. Informant: Mrs. Annie F. Gibson
Address: Nutwell, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6 1947 (month) (day) (year)
Cemetery or crematory: St James Chapel
Location: Bradley Md.

18. Funeral director: T. A. Hardesty & Son
Address: Galesville, Md

19. Mar 4 1947 (Date rec'd by registrar) D. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 19 47, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 6 19 47, to March 3 19 47.
and that I last saw him alive on March 3 19 47.

Immediate cause of death	DURATION
Cerebral hemmhage.	
Due to cerebral arteriosclerosis	
Due to hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D. (M. D. or other)
Address: Lothian, Md. Date signed: 3/4/47

1-35

02429

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 26 Washington
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Julius C. Gross

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Elizabeth Gross
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 2, 1884

8. AGE: Years	Months	Days	If less than one day
62	9	8	..... hrs. ..... min.

9. Birthplace: Anne Arundel Co. (Town, county, and state)
10. Usual occupation: Cook. U.S.N.
11. Industry or business

FATHER
12. Name: Martin Gross
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah (Unknown)
15. Birthplace: Md.

16. Informant: Elizabeth W. Gross
Address: 26 Washington St, Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 14, 1947 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Annapolis, Md
18. Funeral director: J. B. Duson
Address: Annapolis, Md.

19. March 12, 1947 (Date rec'd by registrar) W. D. Dugan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10, 1947, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15, 1947, to March 10, 1947, and that I last saw h. l. alive on March 10, 1947.

Immediate cause of death	DURATION
Carcinoma of head of	
Due to pancreas	
and Liver	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John M. Cleffy M.D. M. D. or other
Address: Annapolis Md. Date signed: 3-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

02430

Reg. Dist. No. 280

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs. 19 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 19 yrs. 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson,
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war ....

3. (a) FULL NAME: Gross - Nathan (Nathaniel)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 1909 ?

8. AGE: Years	Months	Days	If less than one day
38 ?	?	?	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: --

FATHER
12. Name: Daniel Gross
13. Birthplace: Maryland

MOTHER
14. Maiden name: Isabelle Norriss
15. Birthplace: Maryland

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof: March 28, 1947 (month) (day) (year)

Cemetery or crematory: Pleasant Rest

Location: Baltimore County

18. Funeral director: Byron and Mamie Wright

Address: 721 Aisquith St. Baltimore, Maryland

19. 3/26/47 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24, 1947 at 6:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5, 1928 to March 24, 1947 and that I last saw him alive on March 24, 1947

	DURATION
Immediate cause of death: Epilepsy	Known to us since 12/7/27
Due to: —	
Due to: —	
Other conditions: Epilepsy with Psychosis	Known to us since 12/7/27

(Include pregnancy within 3 months of death)

Major findings of operations: .... Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: .... Injured at work?

23. SIGNATURE: Wm. V. Winterode M. D. or other

Address: Crownsville Maryland Date signed: 3/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02431

Reg. Diat. No. 201

1. PLACE OF DEATH:
County: anne arundel
City or town: Cumberstone, md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs -
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: maryland. County: Anne arundel
City or town: Cumberstone - md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Morris Hacker

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Widower

6.(b) Name of husband or wife: Sue W. Cheston Hucker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 29th 1866

8. AGE: Years: 80 | Months: 4 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Phila Pa.
(Town, county, and state)

10. Usual occupation: Retired Coal Engineer.

11. Industry or business

FATHER 12. Name: Morris Hacker
13. Birthplace: Philadelphia - Pa.

MOTHER 14. Maiden name: Isabel Wetherill
15. Birthplace: Philadelphia - Pa.

16. Informant: Susan Cheston Hacker.
Address: Cumberstone, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 3-5-47 (month) (day) (year)
Cemetery or crematory: Christ Church - Church Yard
Location: West River. - Md.

18. Funeral director: John M. Taylor & Son
Address: Annapolis - Md.

19. March 4 1947 (Date rec'd by registrar) M. M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to March 3 1947, and that I last saw him alive on March 2 1947.

Immediate cause of death	DURATION
Chronic myocarditis	
Due to: arter sclerosis -	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Emily H. Wilson M.D. (M. D. or other)
Address: Lothian, Md. Date signed 3/3/47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 12432 58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs. 2 mos. 7 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 8 yrs. 2 mos. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2926 McCulloh Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Hall - Charles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): ~~1904~~ -11-16-09

8. AGE: Years	Months	Days	If less than one day
37	3	20	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: /

MOTHER

12. Name: John Hall

FATHER

13. Birthplace: Baltimore, Maryland

MOTHER

14. Maiden name: Irene Shitzer

15. Birthplace: Philadelphia, Pa.

16. Informant: Hospital Records, Crownsville State

Address: Hospital, Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof? 3-10-47 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem.

Location: Balto., Md.

18. Funeral director: Charles R. Law

Address: 802 Madison Avenue, Baltimore 1, Md.

19. 3/10 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 1947, at 11:55AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 28 1938, to March 7 1947

and that I last saw him alive on March 7 1947

	DURATION
Immediate cause of death: Coronary Occlusion	One Hour
Due to:	
Due to:	
Other conditions: Paranoid Condition (Include pregnancy within 3 months of death)	Known to Us since 12/28/38

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 3/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

02433

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Lusby, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: A.A. Co.
City or town: Rural, Lusby, Md. Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elzena Hall

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Jeremiah Hall
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1866

8. AGE: Years	Months	Days	If less than one day
81			hrs. min.

9. Birthplace: Taylorsville, A.A.Co. Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Thomas Jones
13. Birthplace: Md.

MOTHER
14. Maiden name: Anna Parker
15. Birthplace: Md.

16. Informant: Martha Brown
Address: Lusby, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 13, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Tabot
Location: Chesterfield, Md.

18. Funeral director: J.B. Johnson
Address: Annapolis, Md.

19. Mar. 10 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10, 1947 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 8 1947, to March 10, 1947
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardiac Failure	4 dy
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 40 Tuxhorn Ave Date signed: 3/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A5 9-45-15M

1-35

(Over)for clarrification of name

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

02434

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 106 S. Caroline
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hamilton - Melvin or (Henderson)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Latvina Henderson
6.(c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
50 ?	?	?	...hrs. ...min.

9. Birthplace S. Carolina (Town, county, and state)
10. Usual occupation Concrete Mixer
11. Industry or business

FATHER
12. Name Walter ?
13. Birthplace S. Carolina

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Hospital Records, Crownsville State
Address Hospital, Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 3/24/47 (month) (day) (year)
Cemetery or crematory Hospital
Location Crownsville
18. Funeral director Supt. Hospital
Address Crownsville

19. 3/24/47 (Date rec'd by registrar) E. Joyce Lucas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 19 47 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Ma February 12 19 47 to March 11 19 47
and that I last saw him alive on March 11 19 47

Immediate cause of death	DURATION
	Known to us since Feb. 12, 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Injured at work?
Means of injury

23. SIGNATURE Hal J. Brantford M. D. or other
Address Crownsville, Maryland Date signed 3/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Statement was received from Crownsville, State Hospital on Mar. 29, 1947 to the effect that:

Deceased came to Crownsville State Hospital under the name of Hamilton. At his death, March 11, 1947, his relatives informed us his name was Henderson. We have no idea why he chose the alias "Hamilton" but since he claimed it was his name, we have him on our records as Hamilton instead of Henderson. To keep our records straight we put the name Hamilton on the death certificate, and in parenthesis the name (Henderson) for the benefit of relatives who may have had insurance policies on patient in his right name. We have no positive way of determining which name is correct.

Letter in letter file under Crownsville, State Hospital.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-0)

CERTIFICATE OF DEATH

02435 1

Reg. Diat. No. 211

1. PLACE OF DEATH:
County Anne Arundel
City or town Magothy Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Magothy Beach
(If outside city or town limits, write RURAL and give nearest town)
Pasadena P.O., Md
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lula Louise Hardy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	married

6.(b) Name of husband or wife Harry Hardy
6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1895

8. AGE: Years	Months	Days	If less than one day
51	5	6	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business own home

FATHER
12. Name William Zell
13. Birthplace Baltimore Md.

MOTHER
14. Maiden name Wilhelmina Hohman
15. Birthplace Baltimore Md.

16. Informant Harry E. Hardy
Address Anne Arundel Co. Magothy Beach

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Mar. 9, 1947
(month) (day) (year)
Cemetery or crematory New Cathedral
Location Baltimore Md.

18. Funeral director Dill Bros.
Address 3109 Frederick Ave.

19. March 7 1947 A. W. Tedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1947, at 4 00 P M

21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~
Postmortem Examination
~~[illegible]~~ March 5 1947

	DURATION
Immediate cause of death	
Coronary thrombosis	sudden
Due to	
Coronary sclerosis	unknown
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work

23. SIGNATURE John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis, Md. Date signed 3/5/47

VS A15 9-45-15M 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02436

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: a.a. Co.

City or town: Passedena md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs -

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: a.a. Co.

City or town: Passedena Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: none

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Paul Le. Hartman

3. (b) Social Security Number: 219031923

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widower

6.(b) Name of husband or wife: Lucy Hartman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 28 1879

8. AGE:

Years	Months	Days	If less than one day
68	1	1	hrs. min.

9. Birthplace: Balto. md.

(Town, county, and state)

10. Usual occupation: Seaman

11. Industry or business: U.S. Engineers Dept.

FATHER

12. Name: Unknown

13. Birthplace: Md

MOTHER

14. Maiden name: Unknown

15. Birthplace: md

16. Informant: Mrs Amelia Fisher (daughter)

Address: Passedena md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Mar. 31 1947 (month) (day) (year)

Cemetery or crematory: Green mount

Location: Green mount ave.

18. Funeral director: W.m. Cook inc.

Address: 1217 st. Paul st.

19. March 31 19 47 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: mar 29 19 47, at 6-30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26th 47 to Mar 29 19 47

and that I last saw h. alive on mar 28th 19

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to: Chronic Diabetes Mellitus	
Due to: Chronic Endocarditis	
Due to: Arterio Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John H. Alexander M. D. or other

Address: Glen Burnie Md. Date signed 3/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02437

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1709 Westwood Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Irvin Hicks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Henriette Hicks

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	4	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Janitor in shipyard

11. Industry or business: /

FATHER — 12. Name: Isie Hicks

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Ray

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records, Crownsville State

Address: Hospital, Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof March 28, 1947
(month) (day) (year)

Cemetery or crematory: Mt. Auburn Cemetery

Location: Baltimore, Maryland

18. Funeral director: Thomas E. Kelson

Address: 1303 Prestman Street, Baltimore, Md.

19. 3/26/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24, 1947 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4, 1947, to March 24, 1947

and that I last saw him alive on March 21, 1947

Immediate cause of death	DURATION
General Paresis	Known to us since 3/4/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert J. Strickroot, M. D. or other

Address: Crownsville, Maryland Date signed 3/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02438

Reg. Diat. No. 2390

1. PLACE OF DEATH:

County A. A.

City or town Baltimore 25.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 yr.

Hospital, Institution, or street address where death occurred:
6743 Bell Grove Rd.

How long in hospital or institution? ——

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ——— County Same

City or town ———
(If outside city or town limits, write RURAL and give nearest town)

Street No. ———
(If rural, give LOCATION)

2.(a) If veteran, name war ———

3.(a) FULL NAME Charles Henry Hines Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married.

6.(b) Name of husband or wife Sarah Matilda Hines

6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Nov. 1 - 1862

8. AGE: Years 84 | Months 4 | Days 22 | If less than one day ...hrs. ...min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name John Wesley Hines
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden name Lydia Brooks.
15. Birthplace A. A. Co. Md.

16. Informant Sarah Matilda Hines
Address 5743 Bell Grove Rd.

17. Burial Date thereof 3/25/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Calvery

Location Brooklyn, Md.

18. Funeral director Elroy A. Wilson

Address 1000 Brantly ave

19. 26 March 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946, to Mar. 22 1947
and that I last saw h— alive on Mar. 22 1947

Immediate cause of death	DURATION
Cardio-Vascular Renal	4 mos.
Due to	
Due to	
Other conditions Enlarged Prostate	3 mos.
Retention	

(Include pregnancy within 3 months of death)

Major findings of operations ———

Date of op. ———

Autopsy results ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work?

23. SIGNATURE Chas. L. Bare Jr. M.D.
M. D. or other

Address Littlestown Pa. Date signed 3-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47C

CERTIFICATE OF DEATH

Reg. Dist. No. 29 02439

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Days
Hospital, Institution, or street address where death occurred:
Station Hospital, Ft. Geo. G. Meade, Md.
How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Arkansas County:
City or town: Springdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 324 Laura St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I & II

3.(a) FULL NAME
FRANK C. HUTCHESON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Viola V. Hutcheson
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): April 9, 1899

8. AGE: Years	Months	Days	If less than one day
47	11	3	....hrs. ....min.

9. Birthplace: Gravett, Arkansas (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business
FATHER 12. Name
FATHER 13. Birthplace
MOTHER 14. Maiden name
MOTHER 15. Birthplace
16. Informant: Medical Records
Address: Station Hospital, Ft. Geo. G. Meade, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-15-47 (month) (day) (year)
Cemetery or crematory: Burns Funeral Home
Location: Bentonville, Arkansas
18. Funeral director: Lon Chambers Co.
Address: Rinando Funeral Home
19. 12 March 1947 (Date rec'd by registrar) BERNARD F. KERWIN, Capt., Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 MARCH 1947 at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 March 1947 to 12 March 1947 and that I last saw him alive on 12 March 1947

Immediate cause of death	DURATION
Respiratory failure	
Due to: Pulmonary abscess, possible bronchogenic carcinoma	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None performed Date of op.
Autopsy results: None performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: THOMAS W. MATTINGLY, Lt. Col. M.C. M. D. Author
Address: Sta Hosp, Ft. G.G. Meade, Md. Date signed 17 Mar. 47

PC

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

STATION HOSPITAL
Fort George G. Meade, Maryland

BFK/flb

AIC PM-R

19 March 1947

Special Agent, U. S. Bureau of the Census
c/o State Department of Health
2411 North Charles Street
Baltimore 18, Maryland

Dear Sir:

Inclosed herewith death certificate & pink copy in the case of FRANK C. HUTCHESON, a veteran of World War I & II, who died at this hospital on March 12 , 1947.

No additional information is available in this case other than that which appears on the death certificate. It is understood at this office that if additional information pertinent to this case is desired such information can be obtained by contacting the Veterans Administration Regional Office No. 12, 1825 H Street, N. W., Washington 25, D. C.

Very truly yours,

Ernest Herwin

BERNARD F. KERWIN
Captain, PC
Registrar

1 Incl
Original & pink copy of
Death Certificate

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02440

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 36 Lafayette Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles H. Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Hannah Johnson

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): April 11, 1864

8. AGE: Years	Months	Days	If less than one day
82	11	21	..... hrs. ..... min.

9. Birthplace: Ann Arundel Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Charles H. Johnson

FATHER — 13. Birthplace: A.A.Co. Md.

MOTHER — 14. Maiden name: Mary Johnson

MOTHER — 15. Birthplace: A.A.Co. Md.

16. Informant: Rev. Charles O.. Johnson

Address: 36 Lafayette Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 26, 1947 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis, Md.

18. Funeral director: J.B.Johnson

Address: Annapolis, Md.

19. March 26 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 19 47 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 19 47, to March 23 19 47

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	Apoplexy	DURATION 2 days
Due to	Hypertension	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: T. H. Johnson M. D.
M. D. or other

Address: 40 Northwest Street Date signed: 3/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

Dr. Claffy

02441

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County A. A.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

23 O'Bryant st

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A. A.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 O'Bryant st

(If rural give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isaac Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Georgie Jones

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace Winfield A. A. Co.

(Town, county, and state)

10. Usual occupation U.S.N. Mess Attd

11. Industry or business

FATHER 12. Name Peter Jones

13. Birthplace Md.

MOTHER 14. Maiden name Lydia Blandford

15. Birthplace Md.

16. Informant Florence Smith

Address 36 Gotts Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 31 1947 (month) (day) (year)

Cemetery or crematory U.S. National Cemetery

Location Annapolis

18. Funeral director J. B. Johnson

Address Annapolis

19. March 31 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 26 1947, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~ Post mortem Examination ~~[illegible]~~ March 26 1947

	DURATION
Immediate cause of death	
Cerebral Hemorrhage	Sudden
Due to	
General Arterio-sclerosis	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Claffy M.D. Deputy Medical Examiner

M. D. or other

Address Annapolis, Md. Date signed 3/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-a)

CERTIFICATE OF DEATH

02442

Reg. Dist. No. 231

1

1. PLACE OF DEATH:

County A. A.

City or town Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Old Mill Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Same

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Wm Kiessling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W.	single

6.(b) Name of husband or wife none

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16 - 1946

8. AGE: Years	Months	Days	If less than one day
	5	3	hrs. min.

9. Birthplace Baltimore md (Hosp)

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

MOTHER FATHER

12. Name Wilbert Kiessling

13. Birthplace Baltimore

MOTHER

14. Maiden name Mary Rabin

15. Birthplace Baltimore — md.

16. Informant Wilbert Kiessling

Address Severn Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-2-47 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glenburnie Md

18. Funeral director Geo. A. Tharp

Address Guilford & Fayette Sts Balto Md

19. 3/19/47 (Date rec'd by registrar) Mrs Allen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19 1947, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 16 - 1946 to Mar. 19 1947 and that I last saw h— alive on Mar. 19 1947

Immediate cause of death	DURATION
Strangulation due to Hanging	1 hr.
Due to Cold & Bronchitis —	4 days
Dof some cold & phlegm	
Due to I was put in crib &	
was dead when found	
Other conditions 5 hr. later —	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bacon Jr. M.D. M. D. or other

Address Centerline Date signed 3-19-47

M

C

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

★ 02443

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: A. A. Co.
City or town: near Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: A. A.
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THRESA LITZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	WIDOWED.

6.(b) Name of husband or wife: VINCENT - J.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): FEB - 3 - 1889.

8. AGE: Years: 58. Months: Days: If less than one day: hrs. min.

9. Birthplace: ITALY. (Town, county, and state)
10. Usual occupation: HOUSE WIFE
11. Industry or business
MOTHER FATHER 12. Name: ANGELO CHIPREAN.
13. Birthplace: ITALY.
MOTHER 14. Maiden name: NELLIE COX.
15. Birthplace: ITALY.
16. Informant: VICTOR W. LITZ.
Address: 6631 - HILLANDALE, RD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 2, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: W W Chambers Co.
Address: 1400 - CHAPIN - ST Wash DC
19. 3/30/1947 (Date rec'd by registrar) Mae Allen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1947 to March 29 1947 and that I last saw h... alive on March 29 1947

	DURATION
Immediate cause of death: Myocardial in- sufficiency & pulmonary edema	1 day
Due to: Chronic Myocarditis	1 year
Due to: Hypertension	appx. 10 yrs.
Other conditions: Arthritis of spine & lower extremities	15 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Stephens M.D. M. D. or other
Address: Laurel, Maryland Date signed: 3/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02444

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 316 Adams St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mildred B. Lowman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Gordon E. Lowman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 7th 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51	8	5		

9. Birthplace: York Pa. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: William Vaughn
13. Birthplace: Penn.

MOTHER
14. Maiden name: Gertrude Grim
15. Birthplace: Penna

16. Informant: Gordon E. Lowman
Address: 316 Adams St. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar-14-1947 (month) (day) (year)
Cemetery or crematory: Glen Haven Memorial
Location: Glen Burnie Md.

18. Funeral director: John M. Taylor Son
Address: Annapolis Md

19. March 14, 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1947, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1947, to March 12 1947
and that I last saw h[illegible] alive on 3/11/47 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr.
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Lee Lucas M. D. or other
Address: Eastport Md Date signed 3/12/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02445

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kings Arc
City or town: Severna Pk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A A Co.
City or town: Severna Pk.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Hector C. Mac Rae

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of husband or wife: Annie M.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 20-1872

8. AGE:

Years	Months	Days	If less than one day
74	10	19	..... hrs. ..... min.

9. Birthplace: Canada. (Town, county, and state)
10. Usual occupation: Battery Business
11. Industry or business: Self.
12. Father — Name: Donald Mac Rae
13. Father — Birthplace: Canada.
14. Mother — Maiden name: Mary Campbell
15. Mother — Birthplace: Canada.
16. Informant: Annie M. Mac Rae
Address: Severna Pk.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 3/11/47 (month) (day) (year)
Cemetery or crematory: Loudon Pk.
Location: Balto Md
18. Funeral director: Wm Cook Inc
Address: 1217 St Paul St
19. 3/10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 9-47 19..... at 3:40 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47, to Mar 9 19 47 and that I last saw h... alive on March 8 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage.	2 months
Due to: Cardio - Vascular Renal	5 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James S. Bullington M.D
M. D. or other
Address: Glen Burnie Md Date signed Mar. 9, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02446 P

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS A15

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Rivera Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:
home

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Rivera Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No. Dale Road
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Samuel Frederick Mainster

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie L.

Feb. 20, 1870 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1870

8. AGE:

Years	Months	Days	If less than one day
77	1	5	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Filling Station Owner

11. Industry or business

FATHER
12. Name: Samuel Mainster
13. Birthplace: Maryland

MOTHER
14. Maiden name: Josephine T.
15. Birthplace: Maryland

16. Informant: Mrs. Annie L. Mainster
Address: Dale Road, Rivera Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 27, 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Maryland

18. Funeral director: Wm. Cook, Inc.

Address: 1217 St. Paul Street

19. 3/26 47 (Date rec'd by registrar) H. W. Riddick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1947, at 3 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947, to Mar 25 1947 and that I last saw him alive on March 25 1947

Immediate cause of death	DURATION
Coronary occlusion	2 hrs
Due to: Arterial Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thos. H. Phillips M. D. or other

Address: 1939 Edmondson Ave. Date signed: Mar 25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 02447

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months 7 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 6 months 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1123 E. Pott Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mason - Ida

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married ?

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
50 ? 55 ?	?	?	...hrs. ...min.

9. Birthplace: W. Va.
(Town, county, and state)

10. Usual occupation: Laundry Worker

11. Industry or business: ?

FATHER
12. Name: Henry Mason
13. Birthplace: Va.

MOTHER
14. Maiden name: Gladys ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Hospital Cemetery

Location: Crownsville, Maryland

18. Funeral director: Junk.

Address: Crownsville Md

19. March 12 1947 E. Joyce Rocap
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 19 47 at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 23 1946, to March 2 1947

and that I last saw her alive on March 2 1947

Immediate cause of death	DURATION
General Paresis	Known to us since Aug. 23, '46
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert J. Brinkerhoff M. D. or other

Address: Crownsville, Maryland Date signed: 3/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

02448

★ Reg. Diat. No. 28

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yr. 3 mos. 9 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 26 yrs. 3 mos. 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County aa

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 78 Pleasant Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mathews - John

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
64 ?	?	?	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Frank Mathews

13. Birthplace ?

MOTHER 14. Maiden name Eliza Johnson

15. Birthplace Maryland

16. Informant Crownsville Hospital Records

Address Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March (month) , 1947 (day) (year)

Cemetery or crematory Hospital Cemetery

Location Crownsville, Maryland

18. Funeral director Asst. Crownsville

Address

19. March 12 1947 (Date rec'd by registrar) E.F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 25 1920, to March 6 1947

and that I last saw h.im alive on March 6 1947

Immediate cause of death	DURATION
Due to	
Due to	
Other conditions Dementia Praecox; Paranoid Type (Include pregnancy within 3 months of death)	Known to us since 11/25/20

Major findings of operations ..... Date of op. .....

Autopsy results Nephrosclerosis, Cardiac Hypertrophy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address ..... Date signed 3/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02449

Reg. Dist. No. 27 6

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred:
Dispensary "A", Ft. Geo. G. Meade, Md.

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1804 E. North Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: ISABEL MARY McCARTHY

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): MARCH 21, 1947

8. AGE: Years	Months	Days	If less than one day
-	-	-	4 hrs. ... min.

9. Birthplace: Fort George G. Meade, Anne Arundel, Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: -

FATHER
12. Name: Albert L. McCarthy, S/Sgt., U. S. Army
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Isabel Robier
15. Birthplace: Baltimore, Maryland

16. Informant: Medical Records
Address: Station Hospital, Ft. Geo. G. Meade, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 24 March 1947 (month) (day) (year)

Cemetery or crematory: Post Cemetery

Location: Fort George G. Meade, Maryland

18. Funeral director: Howard N. Blight, Jr. HOWARD N. BLIGHT, JR.

Address: 4914 Belair Road, Baltimore 6, Maryland

19. 21 March 1947 (Date rec'd by registrar) BERNARD F. KERWIN, Capt., Registrar

PC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 March 1947, at 2215 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 March 1947, to 21 March 1947 and that I last saw her alive on 21 March 1947

Immediate cause of death	DURATION
Marked Atelectasis	
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Lowell F. Peterson Capt. M.C.
LOWELL F. PETERSON, Capt., M. C., or other

Address: Disp. A, Ft. G. G. Meade, Md. Date signed: 3-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15-1

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

★ 02450 Reg. Dist. No. 2/0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: a a
City or town: annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 minutes
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: a a
City or town: Sudley (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Baby Miller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
+	w	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 14 1947

8. AGE: Years | Months | Days | If less than one day: hrs. 25 min.

9. Birthplace: annapolis md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Frank J Miller
FATHER 13. Birthplace: Balto. md
MOTHER 14. Maiden name: Florence J Owen
MOTHER 15. Birthplace: Virginia

16. Informant: Frank J Miller
Address: Sudley md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 15/47 (month) (day) (year)
Cemetery or crematory: St Margts
Location: Annapolis md

18. Funeral director: B. L. Hopkins & Son
Address: Annapolis Md

19. March 14 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 14 1947, at 2 05 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 14 1947, to Mar 14 1947
and that I last saw h... on ...alive on Mar 14 1947

Immediate cause of death	DURATION
prematurity	
(Cause spontaneous)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Bowman MD M. D. or other
Address: Annapolis Md Date signed 3/14/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

02451 26

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 11 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 2 months 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2325 Pennsylvania Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Henry Nichols

3.(b) Social Security Number: 217-07-6671

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mrs. Henry Nichols (Avonia)
6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1892 Aug 30.

8. AGE: Years 54 | Months 6 | Days 0 | If less than one day: hrs. min.

9. Birthplace: ? Baltimore, Md.
(Town, county, and state)

10. Usual occupation: ? Porter

11. Industry or business: ? Clothing House

FATHER
12. Name: ? Henry L. Nichols
13. Birthplace: ? Md.

MOTHER
14. Maiden name: ? Clara Ruggles
15. Birthplace: ? Md.

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 6, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.

18. Funeral director: John M. Johnson
Address: 1760 Druid Hill Ave

19. 3/4/47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1947, at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 1946, to March 2 1947
and that I last saw him alive on March 2 1947

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	Known to us since 12/19/46
Due to:	
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 12/19/47

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other
Address: Crownsville, Maryland Date signed: 3/2/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

02452

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 122 Chesapeake Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James W. Parkinson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth T. Parkinson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug 14th 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	7	6		

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: Molder Ret.
11. Industry or business: U.S. Naval Academy.
FATHER 12. Name: Philip Parkinson
13. Birthplace: a a co Md.
MOTHER 14. Maiden name: Clara Popham
15. Birthplace: Annapolis Md.
16. Informant: Mrs Elizabeth T. Parkinson
Address: 122 Chesapeake Ave Eastport Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar-23rd 1947 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. March 21 19 47 (Date rec'd by registrar) W. D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 19 47 at 7 30 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 18 19 47 to Mch 20 19 47
and that I last saw h... alive on March 20 19 47

Immediate cause of death	DURATION
Broncho Pneumonia	2 Days
Due to Auricular Fibrillation	Several Months
Due to Anemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Purves M. D. or other
Address: Annapolis Md. Date signed 3/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

CERTIFICATE OF DEATH

02453

Reg. Diat. No. 614

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Anne Arundel

City or town Rural - Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yr. 1 mo. - 2 day

Hospital, institution, or street address where death occurred:

District Training School

How long in hospital or institution? 12 yr 1 mo - 2 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Rural - Laurel, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Robert Darryl Patterson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 18, 1903

8. AGE:

Years	Months	Days	If less than one day
43	7	22	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name John C. Patterson

FATHER 13. Birthplace ?

MOTHER 14. Maiden name Mary C.

MOTHER 15. Birthplace ?

16. Informant History, Record of D. T. S.

Address Laurel, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Mar 10 - 47 (month) (day) (year)

Cemetery or crematory ..... Md.

Location Bethesda

18. Funeral director W. M. Reuben Pumphrey

Address Bethesda Md.

19. Mar 10 1947 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947 at 900 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1935 to March 1947 and that I last saw h... alive on Mar 10 1947

Immediate cause of death	DURATION
Pneumonia (Hypostatic)	24 hrs
Due to	.....
Due to	.....
Due to	.....
Other conditions Epilepsy	.....
Mental Deficiency-Imbecile	.....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Richard Otterbein M. D. or other

Address District Training School Laurel Md Date signed 3-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-a)

02454

CERTIFICATE OF DEATH

Reg. Dist. No. 200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Edgewater (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months

Hospital, institution, or street address where death occurred: Home Woodland Beach

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: A-A

City or town: Rural - Edgewater (If outside city or town limits, write RURAL and give nearest town)

Street No.: Woodland Beach (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ellen Delilah Payton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Louis M. Payton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 7, 1863

8. AGE: Years	Months	Days	If less than one day
83	11	30	..... hrs. ..... min.

9. Birthplace: Prince George's Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Thomas Carroll

13. Birthplace: Maryland

MOTHER 14. Maiden name: Littlefod

15. Birthplace: —

16. Informant: Mrs. Antill

Address: Woodland Beach, Md.

17. Burial (Burial, cremation, or removal—Which?) Date thereof 3/10/47 (mooth) (day) (year)

Cemetery or crematory: Forest Lawn Cemetery

Location: Richmond Virginia

18. Funeral director: W. W Chambers Co

Address: 517-11th St. S.E.

19. March 6th 1947 (Date rec'd by registrar) Edward Colleman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1947, at 11:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1946, to March 5 1947 and that I last saw h-r alive on March 6, 1947

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Cardiac dilatation	
Due to: Aortic insufficiency	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. Peyton Ritchings, M.D. M. D. or other

Address: 199 Gloucester St Annapolis, Md. Date signed March 6, 1947

2-35

Dr Claffy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (111-2)

CERTIFICATE OF DEATH

02455

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? July 14 1943
Hospital, Institution, or street address where death occurred:
Lived in this town 3 yrs 9 mos.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 Clay St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Irving Pipes (stranger)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	Colored	Unknown

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) unknown 1890

8. AGE: Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace: Unknown (town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Ancient City Lodge 170
Address 71 Northwest st
17. Buried (Burial, cremation, or removal. Which?) Date thereof Mar. 22 1947 (month) (day) (year)
Cemetery or crematory St. Ann
Location Annapolis, Md.
18. Funeral director J. B. Johnson
Address Annapolis
19. March 21 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19 1947 at 8 20 P M

21. I CERTIFY that death occurred on the date above stated: ~~examination~~ Postmortem Examination ~~examination~~ Mar. 19 1947

Immediate cause of death	DURATION
Acute Paroxysmal Pulmonary Edema	sudden
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John N. Claffy M.D. Deputy Medical Examiner
M. D. or CMCE
Address Annapolis, Md Date signed 3/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24 02456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACESED:
(For newborn infants give residence of mother)
State: Md. County: A. A. C.
City or town: Galesville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: James Pratt

3.(b) Social Security Number: none

4. Sex: Male
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary Pratt
6.(c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.): Oct 1 1899

8. AGE: Years: 57 Months: 5 Days: 4 If less than one day: hrs. min.

9. Birthplace: Lothian Md (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business:
FATHER 12. Name: Alexander Pratt
13. Birthplace: Lothian Md
MOTHER 14. Maiden name: Matilda Anderson
15. Birthplace: Mc Kendree
16. Informant: Matilda Gross
Address: Parole Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 9/47 (month) (day) (year)
Cemetery or crematory: Dan'l Star
Location: West River Md
18. Funeral director: E. G. Hardesty & Son
Address: Galesville Md
19. March 6 19 47 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 19 47 at 10 [illegible] M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb Dec 6 19 46, to March 5 19 47
and that I last saw h[illegible] alive on March 5, 19 47

	DURATION
Immediate cause of death: Apoplexy	
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. W. Johnson Jr. M. D. or other
Address: 60 Parkwood Street Date signed: 3/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

02457

CERTIFICATE OF DEATH

Reg. Diat. No. 280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 2-45-15M (1)

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? F 1 month 5 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 month 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

Street No. Talbot Welfare Board
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Raikes - Rachel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Unknown

6.(b) Name of husband or wife ?

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
71	?	?	...hrs. ...min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation ?

11. Industry or business ?

FATHER 12. Name ?

FATHER 13. Birthplace ?

MOTHER 14. Maiden name ?

MOTHER 15. Birthplace ?

16. Informant Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. burials (Burial, cremation, or removal. Which?) Date thereof 4/2-47 (month) (day) (year)

Cemetery or crematory Hospital

Location Crownsville

18. Funeral director Supt Hospital

Address

19. Apr 2 1947 E J Joyce Lord
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 47, at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 19 47 to March 23 19 47

and that I last saw her alive on March 23 19 47

Immediate cause of death	General Arteriosclerosis	DURATION: Known to us since 2/18/47
Due to	Senile Psychosis	Known to us since 2/18/47
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Albert J Amickrods M. D., or other

Address ... Date signed ...

1-83

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02458

Reg. Dist. No. 280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 945-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yrs. 4 months.

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 31 years 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 932 Druid Hill Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Rebecca Respress

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): 1883 ?

8. AGE: Years	Months	Days	If less than one day
64 ? 65 ?	?	?	...hrs. ...min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ?

FATHER
12. Name: Silas Respress
13. Birthplace: 1123 Druid Hill Ave.

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. burial (Burial, cremation, or removal. Which?) Date thereof 3/11. 47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville, Md.

18. Funeral director: Supt. Crownsville Md

Address

19. March 11 1947 (Date rec'd by registrar) E. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 19 47 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29 19 15 to March 1 19 47 and that I last saw her alive on March 1 19 47

Immediate cause of death: Chronic Myocarditis — DURATION: Four wks.

Due to:

Due to:

Other conditions: Schizophrenia; Paranoid type Known to us since 10/29/1915
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

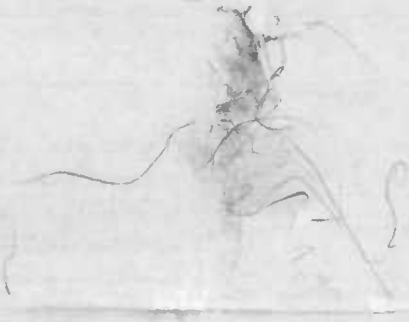
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert J. Winkler M. D. or other

Address: Crownsville, Maryland Date signed: 3/1/47



1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ha)

CERTIFICATE OF DEATH

★ 02459

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 132 Conduit
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anne Cecelia Sears

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: Robert L. Sears
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 12th 1885

8. AGE:

Years	Months	Days	If less than one day
62	2	11	hrs. min.

9. Birthplace: Annapolis Md
(Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: Henry Jackson
13. Birthplace: Maryland
MOTHER 14. Maiden name: Francis Brewer
15. Birthplace: Annapolis Md.
16. Informant: Robert L. Sears
Address: 132 Conduit St. Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-26-1947 (month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md
19. March 26 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 1947, at 11 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to March 23 1947
and that I last saw h[illegible] alive on March 23 1947
Immediate cause of death: Cardio Vascular Failure — DURATION: Fifteen days
Due to: Coronary Artery Disease — DURATION: since Oct 10/46
Due to: Arteriosclerosis — DURATION: Several yrs.
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Oliver Purvis M. D. or other
Address: Annapolis Md Date signed: 3/25/47

1 - 3J

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

CERTIFICATE OF DEATH

02460

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Anne-Arundel

City or town Rural - Severn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne-Arundel

City or town Rural - Severn
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war N

3.(a) FULL NAME Oliver Luvene Short

3.(b) Social Security Number 215-18-7848

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife Margaret Estelle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 6 1873

8. AGE: Years	Months	Days	If less than one day
74	~~X~~ 1	25	..... hrs. ..... min.

9. Birthplace Brandywine - Prince Georges Co - Md
(Town, county, and state)

10. Usual occupation Electrician's Helper

11. Industry or business Electric Railroad Co

FATHER
12. Name Luvene Lodge Short
13. Birthplace Anne-Arundel Co - Md

MOTHER
14. Maiden name Anne Head
15. Birthplace Anne-Arundel Co - Md

16. Informant Rufus Irwin Short

Address Severn Md.

17. Burial Date thereof March 4th 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ Pumphreys

Location Severn Md.

18. Funeral director William Cook Inc

Address 1217 St. Paul St

19. 3-7 1947 [signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947, at 4.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Febuary 21 1947, to March 1 1947

and that I last saw h.. l.. alive on March 1 1947

	DURATION
Immediate cause of death: Cerebral Thrombosis	8 days
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Edward J Merritt M.D.
M. D. or other

Address Gambrills Md Date signed Mar 1, 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

cc 02461 22

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo 17 days

Hospital, institution, or street address where death occurred:

District Training School

How long in hospital or institution? 2 mo 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3739 Jay St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Laverne Geonne Terrell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 - 23 - 40

8. AGE:

Years	Months	Days	If less than one day
6	10	25	hrs. min.

9. Birthplace: D.C.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER

12. Name: Joseph A. Terrell

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Gladys Gray

15. Birthplace: D.C.

16. Informant: Records of Institution

Address: Laurel Md

17. Burial, cremation, or removal. Which?: removal Date thereof: 3 18 47 (month) (day) (year)

Cemetery or crematory: Payne Cem. 3/20/47

Location: Washington D.C.

18. Funeral director: Allen & Mangum Inc.

Address: 1226 U St. N.W.

19. (Date rec'd by registrar): 3-18 19 47

Registrar: Elana Hasluth

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-18 19 47 at 5-15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-31- 19 47 to 3-18 19 47

and that I last saw her alive on 3-17-47 19

Immediate cause of death	DURATION
Epileptic state	17 hours
Due to: Epilepsy	6½ years
Due to:	
Other conditions: Mental deficiency (idiocy)	6½ years
Enteritis	48 hours

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James Lowell MD

M. D. or other

Address: District Tr. School Date signed: 3/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02462

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a. a.

City or town: Ferndale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 - Yr.

Hospital, institution, or street address where death occurred: Annapolis Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: a. a.

City or town: Ferndale

(If outside city or town limits, write RURAL and give nearest town)

Street No. Annapolis Rd. opposite R. R. Station

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Wm Henry Thomas Jr.

3.(b) Social Security Number: 215-10-8875

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth Thomas

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 22 - 1901

8. AGE: Years: 45 | Months: 9 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Hagerstown (Town, county, and state)

10. Usual occupation: Tavern Keeper.

11. Industry or business: Own Business

FATHER — 12. Name: Wm Henry Thomas Sr.

FATHER — 13. Birthplace: Hagerstown

MOTHER — 14. Maiden name: Bessie M. Fridinger

MOTHER — 15. Birthplace: Hagerstown Md.

16. Informant: Ruth Thomas

Address: Ferndale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: a. a. Co. Md.

18. Funeral director: William Cook Inc.

Address: 127 St. Paul St.

19. 3/28 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1947, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1946 to Mar. 26 1947

and that I last saw him alive on Mar. 26 1947

Immediate cause of death: Coronis - Pneumonia Due to

	DURATION
Coronis - Pneumonia	2 days
Due to	
Due to	
Other conditions: Hypertension	1 Yr.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: injured at work?

23. SIGNATURE: Chas. L. Ball M.D. M. D. or other

Address: Ferndale Md. Date signed: 3-26-47

Evidence for the change of age is shown on

FILM No. G 11 MAY 1 1947

02463

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County A. A. C. B.

Registration Dist. No. 25

Village or City Cherry Lane - Brooklyn No. St.: Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME ELIZABETH THORTON

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: Female. 4 COLOR OR RACE: Colored. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married	16 DATE OF DEATH: March 25, 1947 (Month) (Day) (Year)
6 DATE OF BIRTH: Dec 15, 1898 (Month) (Day) (Year)	17 I HEREBY CERTIFY, That I attended the deceased from 1945 to March 25, 1947, that I last saw her alive on March 25, 1947, and that death occurred on the date stated above, at 7:00 P m.
7 AGE: 49 (48) yrs. 3 mos. 10 ds. If LESS than 1 day ... hrs. or ... min.?	The CAUSE OF DEATH * was as follows: Myocardial Insufficiency & Malignant Hypertension long Duration One Year (Duration) yrs. mos. ds.
8 OCCUPATION (a) Trade, profession or particular kind of work: None. (b) General nature of industry business, or establishment in which employed or (employer)	Contributory Secondary (Duration) yrs. mos. ds.
9 BIRTHPLACE (State or country): Middlesex ~~Hatton~~ Va.	(Signed) Leon J. Harley M. D.
PARENTS: 10 NAME OF FATHER: Joseph Whiten	3/27 1947 (Address) 4900 Penn Ave Pa.
11 BIRTHPLACE OF FATHER (State or country): Middlesex Va	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.
12 MAIDEN NAME OF MOTHER: Sarah Carter	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
13 BIRTHPLACE OF MOTHER (State or Country): Middlesex Va.	At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds. Where was disease contracted, if not at place of death? Former or usual residence
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Ellsley Thorton (Address) Cherry Lane Brooklyn A.A. Co.	19 PLACE OF BURIAL OR REMOVAL: Mt. Auburn. DATE OF BURIAL: 3-29, 1947
15 Filed 3/28 1947 A. W. Hedrick Registrar DW	20 UNDERTAKER: Mrs. Katie R. Williams. ADDRESS 322 N Schroeder St.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02464

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: A.A.

City or town: Homewood (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 Years

Hospital, institution, or street address where death occurred: I24 N. Woodlawn Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Homewood (If outside city or town limits, write RURAL and give nearest town)

Street No. I24 N. Woodlawn Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Norman E. Tucker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lucy B. Tucker

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Nov 3 1879

8. AGE: Years	Months	Days	If less than one day
67	4	25	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Road Foreman

11. Industry or business: A.A. County

FATHER — 12. Name: John T. Tucker

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Alice Ridgeway

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs Lucy B. Tucker

Address: I24 N. Woodlawn Street Homewood

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 31 1947 (month) (day) (year)

Cemetery or crematory: Hope Chapel

Location: South River

18. Funeral director: B.L. Hopping & Son

Address: Annapolis, Md.

19. March 31 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1947 at 1 43 P.M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination ~~and that I last saw him alive on~~ Mar. 27 1947

	DURATION
Immediate cause of death: Coronary occlusion	Sudden
Due to: Coronary sclerosis	unknown
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner (M. D. or other)

Address: Annapolis, Md. Date signed: 3/28/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

★ 02465

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 198 West St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Wilson Tyler II

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jany 15th 1947

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.
2 | | 5 |

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Thomas Wilson Tyler
13. Birthplace A A Co Md.

MOTHER
14. Maiden name Mary Dunbar
15. Birthplace Baltimore Md.

16. Informant Thomas W. Tyler
Address 198 West St. Annapolis Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Mar 21st 1947 (month) (day) (year)
Cemetery or crematory St Marys
Location Annapolis Md.

18. Funeral director John M. Taylor Son
Address Annapolis Md.

19. March 21 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20-47 19 ..... at 6 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to 3-20- 1947
and that I last saw h[illegible] alive on 3-20-47 19

Immediate cause of death	DURATION
Enlarged Thymus	2 mos
Due to Prematurity	2 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James R. Stanton M.D.
M. D. or other
Address 185 Prince George St. Annapolis, Md. Date signed 3-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02466

93 e

CERTIFICATE OF DEATH

STATE NO. G 110 MAY 7 1947

Reg. Diat. No. Bc

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months 20 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 5 months 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland8 County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1413 Lemon Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Ada Ward

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Joseph Ward

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): ? 1893

8. AGE: Years	Months	Days	If less than one day
~~53~~ 54	?	?	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: - -

FATHER — 12. Name: Frank Ratliff

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Amanda Graham

MOTHER — 15. Birthplace: North Carolina

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/15/47 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Westport, Md.

18. Funeral director: Elroy C. Wilson

Address: 1000 Brant Ave.

19. Mar 15 1947 (Date rec'd by registrar) A. W. Beckwith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1947 at 7:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 1946 to March 11 1947

and that I last saw her alive on March 11 1947

	DURATION
Immediate cause of death: Myodegeneratie Cordis Arteriosclerosis	Known to us since 9/19/46
Other Conditions: Manic Depressive; Psychosis Manic Type	Known to us since June 23, 1935
Due to:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 3/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

#10053
Ward - Ada
Baltimore City
Admitted: September 19,1946
Deid: March 11, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

CERTIFICATE OF DEATH

02467

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 3 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 934 Bay Ridge Ave
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME Bernard Donald ~~Welch~~ Welch

3.(b) Social Security Number 009-07-0540

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Diana M. Welch
6.(c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Aug 2 1911

8. AGE:

Years	Months	Days	If less than one day
35	7	13	...hrs. ...min.

9. Birthplace Vermont (Town, county, and state)
10. Usual occupation Painter
11. Industry or business House academy

FATHER
12. Name William Welch
13. Birthplace New York

MOTHER
14. Maiden name Jennie Spencer
15. Birthplace Vermont

16. Informant Diana M. Welch
Address 934 Bay Ridge Ave Eastport Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof March 17 47 (month) (day) (year)
Cemetery or crematory
Location Burlington Vermont
18. Funeral director Pvt. Hopton & Son
Address Annapolis Md

19. March 17 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947 about at 4 A M

21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ Post mortem Examination ~~[illegible]~~ March 15 1947

Immediate cause of death	DURATION
Suicide by	
Due to Illuminating Gas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Suicide Date of 3/15/47
Where did injury occur? Eastport (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) home
Means of injury gas from kitchen range Injured at work? no

23. SIGNATURE John M. Caffy M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis, Md Date signed 3/15/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

02468

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 13 Cherry Grove Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edgar Alfred White

3.(b) Social Security Number

4. Sex: male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Mrs. Marguerite S. White
6.(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): May 28 1900

8. AGE: Years 46 Months 9 Days 14 If less than one day hrs. min.

8. Birthplace: Annapolis A.A.Co., Md. (Town, County, and state)
10. Usual occupation: Clerk
11. Industry or business: Naval Academy
FATHER 12. Name: William White
13. Birthplace: England
MOTHER 14. Maiden name: Myrtle Clark
15. Birthplace: Annapolis, Maryland
16. Informant: Mrs. M. S. White
Address: 13 N. Cherry Grove Av. Annapolis
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16th 1947 (month) (day) (year)
Cemetery or crematory: St. James Cemetery
Location: No. Mt Zion A.A.Co. Md.
18. Funeral director: Geo. M. Taylor Son
Address: Annapolis Md.
19. March 16 19 47 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 19 47 at 12 A M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem & Examination 19 ... ~~and that I last saw him alive on~~ March 14 19 47

Immediate cause of death	DURATION
Due to: Coronary Thrombosis	Hours
Due to: Coronary Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John M. Cathy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 3/14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 - 35

Mr. Allen

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-E)

CERTIFICATE OF DEATH

02469

Reg. Dist. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Ann Arundel
City or town Jones' Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Rural, Jones' Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Liddie White
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace Jones' A.A.Co. Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Theodore White
13. Birthplace A.A.Co.

MOTHER
14. Maiden name Annie White
15. Birthplace A.A.Co.

16. Informant James White
Address Jones' Station, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 23, 1947 (month) (day) (year)
Cemetery or crematory Carpenters Hill
Location Jones' Station, Md.

18. Funeral director J.B.Johnson
Address Annapolis, Md.

19. March 21 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-11 1947, to 3-18 1947 and that I last saw him alive on 3-17 1947

Immediate cause of death	DURATION
Congestive Heart failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. T. Adams M.D.
Address 17 Annapolis St. Date signed 3-20-47 M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

02470

Reg. Dist. No. 25

1. PLACE OF DEATH:

County A. A. Co.

City or town Brooklyn - Pob - Baltimore 35
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:
203 - 2nd Ave -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)

State County

City or town Same
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur Cromwell Whittemore Jr.

3.(b) Social Security Number 214-12-2427

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	W.	Married.

6.(b) Name of husband or wife Lena Whittemore

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 30 1900

8. AGE:

Years	Months	Days	If less than one day
46	11	~~20~~ 25	...hrs. ...min.

9. Birthplace A. A. Co.
(Town, county, and state)

10. Usual occupation Carpenter -

11. Industry or business

FATHER
12. Name Arthur C. Whittemore Sr.
13. Birthplace A. A. Co.

MOTHER
14. Maiden name Lena Hanaseek
15. Birthplace A. A. Co.

16. Informant LENA WHITTEMORE
Address 203 2ND AVE

17. BURIAL Date thereof 3/28/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CEDAR HILL.

Location RITCHIE HIGHWAY

18. Funeral director JOHN F. DENNY, INC.

Address 715 LIGHT ST.

19. 3/27/47 A.W. Hewitt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 19 47, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 23 19 47 to Mar. 25 19 47 and that I last saw h alive on Mar. 25 19 47

Immediate cause of death Cardio-Vascular Disease — DURATION 6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bale Jr. MD
M. D. or other

Address Linthicum Date signed 3-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02797

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 818 Chesapeake Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Albert Prince Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Katherine E. Williams
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 31st 1884

8. AGE:

Years	Months	Days	If less than one day
62	2	14	hrs. min.

9. Birthplace: Eastport Md
(Town, county, and state)
10. Usual occupation: Mechanist Exp. Station
11. Industry or business: U.S. Naval Academy

FATHER
12. Name: Jonas Williams
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Jack Williams
Address: Eastport A & C Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 17th 1947 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Layton Son
Address: Annapolis Md.

19. March 17, 1947 (Date rec'd by registrar)
C.O., Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1947 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1947 to March 14 1947
and that I last saw h... alive on March 14 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	1 week
Due to:	
Due to:	
Other conditions: Arterio-Sclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of Injury: Injured at work?

23. SIGNATURE: George C Basil M. D. or other
Address: Annapolis Md Date signed: 3-16-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

02471

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, Institution or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles Henry Willingham

3.(b) Social Security Number: 218-03-5060

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Thelma W.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 30, 1904

8. AGE:

Years	Months	Days	If less than one day
42	4	7	hrs. min.

9. Birthplace: Martinsburg W. Va.
(Town, county, and state)
10. Usual occupation: Industrial Eng.
11. Industry or business: Clothing Business
FATHER 12. Name: John Milton Willingham
13. Birthplace: W. Va.
MOTHER 14. Maiden name: Gertrude Sheets
15. Birthplace: W. Va.
16. Informant: Thelma Willingham
Address: 3511 Woodland Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-11-47 (month) (day) (year)
Cemetery or crematory: Meadow Ridge
Location: Severn Md
18. Funeral director: Long & Byers
Address: 5005 Park Heights Ave
19. Mar 11 1947 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 1947 at 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination and that I last saw him ~~alive~~ on March 7 1947

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 3/7/47
Where did injury occur? Sandy Point (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Chesapeake Bay
Means of injury: Drove car over Ferry Slip Injured at work? Deputy Medical Examiner
23. SIGNATURE: John M. Claffy M.D. M. D. or other
Address: Annapolis, Md Date signed 3/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

02472

Reg. Dist. No. 310

1. PLACE OF DEATH:

County A.A.

City or town Annapolis.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4Years

Hospital, Institution, or street address where death occurred:
I Munroe St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis.
(If outside city or town limits, write RURAL and give nearest town)

Street No. I Munroe Court
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Henry. Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Bernadine E. Wilson

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Aug 24 1875

8. AGE: Years	Months	Days	If less than one day
71	6	7	...hrs. ...min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Printer

FATHER 12. Name Frank Wilson

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Ellen Johnson

MOTHER 15. Birthplace Annapolis, Md.

16. Informant Burial--Mrs W.H.Wilson.

Address I Munroe Court Annapolis, Md.

17. Burial Date thereof Mar 6 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys

Location Annapolis, MD.

18. Funeral director B.L.Hopping & Son

Address Annapolis, Md.

19. March 5, 1947 (Date rec'd by registrar) W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar-3 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1946, to Mar 3 1947 and that I last saw h... alive on Mar. 3 1947

Immediate cause of death	DURATION
Gen. Carcinomatosis	2 mos. (?)
Due to Carcinoma of stomach	6 mos (?)
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Borsuck M.D. M. D. or other

Address Annapolis Md Date signed 3/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

02473

Reg. Diat. No. 21

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1411 West
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Anna Margaret Wohlgemuth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Jacob P. Wohlgemuth
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 4th 1864

8. AGE:

Years	Months	Days	If less than one day
82	11	15	hrs. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: John Bernstein
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown
16. Informant: Miss Margaret C. Wohlgemuth
Address: 1411 West St. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 22-47 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John W. Sayer Son
Address: Annapolis Md.
19. March 21 19 47 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 19 47 at 1:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 19 47, to March 19 19 47
and that I last saw h... alive on March 19 19 47

Immediate cause of death	DURATION
Broncho Pneumia	3 days
Due to: Cerebral Arterio Sclerosis	Several Yrs.
Due to: Cr. Myocarditis	Several Yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Alvin Pusey M. D. or other
Address: Annapolis Md. Date signed: 3/21/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02474

CERTIFICATE OF DEATH

Reg. Dist. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Cedar Park, Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred:

721 Rosedale St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: A A

City or town: Cedar Park, Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 721 Rosedale St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME John William Wood

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Celestina L. Wood

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Oct 1 1878

8. AGE: Years	Months	Days	If less than one day
68	5	8	hrs. min.

9. Birthplace: Scotch, Col. Co. Md.
(Town, county, and state)

10. Usual occupation: Dispatcher

11. Industry or business: Railroad

FATHER 12. Name: Joseph S. Wood

FATHER 13. Birthplace: Scotch Col. Co Md

MOTHER 14. Maiden name: Mary F.C. Cooper

MOTHER 15. Birthplace: Annapolis Md

16. Informant: Evelyn Wood

Address: 721 Rosedale St. Cedar Park

17. Cremation Date thereof 3/11/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Washington D.C.

18. Funeral director: T.A. Hardesty & Son

Address: Edmonston Md.

19. March 11, 1947 T. A. Hardesty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1947 at 11 15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to March 9 1947 and that I last saw him alive on March 9 1947

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to	
Due to	
Other conditions Arteriosclerosis Cardiac Asthma	sudden sudden

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George A Boarman M. D. or other

Address: Annapolis Md Date signed: 3-10-47

1-35